VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

August 2, 2023

Ms. Gretchen Cole, Manager
Margaret Pratt Community
210 Plateau Acres
Bradford, VT 05033

Dear Ms. Cole:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **March 28, 2023.** Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M Cota RN

Pamela M. Cota, RN
Licensing Chief

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0659	A. BUILDING: _____ B. WING _____	C 03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGARET PRATT COMMUNITY	210 PLATEAU ACRES BRADFORD, VT 05033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: On 3/28/23 the Division of Licensing and Protection conducted an investigation of one facility reported incident and one complaint. The following regulatory deficiencies were identified:	R100	**Corrective Action to be accomplished** New policy and procedure for pain management. Pain assessment scale has been reviewed and updated by the RN, and Executive Director. Falls Prevention/Supervision/ Mechanical lift policy and procedure were reviewed and updated. by the RN and Executive Director. Bariatric Wheelchair was purchased and is in the facility for resident use.	7/1/23 4/15/23
R127 SS=G	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.b Staff shall provide care that respects each resident's dignity and each resident's accomplishments and abilities. Residents shall be encouraged to participate in their own activities of daily living. Families shall be encouraged to participate in care and care planning according to their ability and interest and with the permission of the resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview there was a failure to provide care with respect for the dignity and abilities of one applicable resident (Resident #1). Findings include: Resident #1 has diagnoses including Unspecified Lack of Expected Normal Physiological Development in Childhood and recurrent Major Depressive Disorder. S/he experiences chronic lower back and knee pain due to arthritis. During the month of February and March of 2023 Resident #1 experienced mental and physical decline. Nursing notes during this time period document increased urinary and bowel incontinence; fecal smearing following episodes of incontinence; attention seeking; regressive behaviors including thumb sucking, child-like	R127	**Measures Implemented to ensure it does not recur**. Responsible employee was re-educated and no longer is employed at MPC. Director of Health Services and Executive Director will audit and ensure compliance with the provision of care with respect to the dignity and abilities of each resident. All Health Services, Management and Resident Services staff will complete gait belt and Hoyer lift training upon new hire. Training will be signed off by the Department Manager and Business Office Manager. The Health Services Coordinator will perform safety and functional audits every 3 months to ensure all DME is appropriate for each resident. *All Staff training on Respectful and Effective interactions with residents.* *Health Services Training: Resident Rights* *All staff Abuse and Neglect Training* *Management Abuse and Neglect Training* *Resident Rights Discussion: MPC Resident Town Hall Meeting.* *Resident informational discussion with Dawn Donahue VT Ombudsman.* *Health Services Assistant Training on Pain Assessment.* *Health Services Assistant Training on the Hoyer lift* **QA Program Action to Monitor compliance with corrective measures.** Our monthly QA monitoring program will now include a review of pain management, falls, Resident Rights, and DME audits (Quarterly).	3/21/23 7/1/23 8/10/23 8/10/23 5/22/23 3/22/23 4/12/23 4/6/23 5/8/2023 7/27/23 8/10/23 7/28/23 8/10/23

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R127	Continued From page 1 speech, and calling staff "Mama". Refusing to walk; abruptly deciding not to walk with poorly controlled sitting down on the floor; and use of a wheelchair and mechanical lift not previously required were also noted. On 3/7/23 Resident #1 sustained an ankle fracture while being ambulated by staff members including the Registered Nurse to the facility's vehicle for transport to a planned inpatient psychiatric hospitalization. Resident #1 had multiple falls on this day. Per record review and staff interview an initial fall occurred on the second floor of the facility prior to lunch on 3/7/23. Staff reported Resident #1 was crying, expressed that s/he was having knee pain, and wanted to sit down; however the RN stated s/he needed to walk. During this incident Resident #1 sustained a fall, and was lifted off the floor by staff. Approximately 10 minutes later Resident #1 was reportedly yelling and crying in the dining room, and was transported to his/her room on a dining room chair with wheels as the facility did not have the appropriate sized wheelchair to accommodate Resident #1's needs. During an interview commencing at 5:30 PM on 3/28/23 the RN stated as Resident #1 was assisted from his/her room to the van for transport the dining room chair with wheels could not pass a door threshold and the RN directed him/her to get up and walk. Resident #1 reportedly paused every few steps and stated s/he could not walk, which during the interview on 3/28/23 the RN associated with the regressive behaviors observed over the previous weeks, and determined "there was no reason s/he could not walk". The RN confirmed s/he did not assess Resident #1 for pain during the incident. Resident #1 fell again in the facility's vestibule as staff	R127	Tag R127 accepted on 8/1/23 - C. Scott	

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R127	Continued From page 2 attempted to ambulate him/her. Per staff interview as Resident #1 sat on the vestibule floor s/he was crying and stated s/he was in pain; and the RN directed staff to get more staff instead of using the mechanical lift to assist Resident #1 off the floor. As s/he was lifted from the floor a gait belt placed around his/her body shifted upwards exposing part of Resident #1's bare body in this common area of the home. As Resident #1 was ambulated towards the van s/he fell again while the RN continued to state s/he needed to walk and could not sit down as there was no chair available. S/he was transported to the emergency room where an ankle fracture was diagnosed. During the interview on 3/28/23 the RN stated Resident #1's walker, which has a seat, was in front of him/her throughout this incident however it was not offered to because it was too small for the resident to sit on. The RN confirmed attempts had not been made to obtain a walker that was the correct size for Resident #1.	R127		
R144 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c.(1) Complete an assessment of the resident in accordance with section 5.7; This REQUIREMENT is not met as evidenced by: Based on record review and staff interview there was a failure to complete a Resident Assessment within 14 days of admission, two annual reassessments, and a change of condition assessment for one applicable resident (Resident #1). Findings include:	R144	**Corrective Action to be accomplished** Review of MPC Policy and Procedure on Assessments by RN, and Executive Director. All MPC Residents have current, updated, and signed VT Resident assessments by the Registered Nurse. **Measures Implemented to ensure it does not recur** Health Services Coordinator keeps a schedule for all initial, annual, and change of condition care plan meetings that include the resident and family/guardian as indicated. The Director of Health Services will audit monthly. The Director of Health Services and Executive Director will perform monthly audits on each resident chart to ensure assessments are being completed in a timely manner.	7/10/23 8/1/23 8/1/23

			Measures Implemented to ensure it does not recur continued from page 3. Resident Concerns including significant changes are discussed weekly at the MPC Leadership Team Meeting. **QA Program Action to Monitor compliance with corrective measures** Our monthly QA monitoring program will now include a review of the admission process, change of condition, and report of completed monthly assessments. Tag R144 accepted on 8/1/23 - C. Scott	7/6/23 8/10/23

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R144	Continued From page 3 1. Resident #1 was admitted to the facility on 12/27/18. At 1:34 PM on 3/28/23 the Executive Director confirmed Resident #1's Resident Assessment form dated 12/29/18 was not signed as completed by a Registered Nurse; and annual reassessments for 2019 and 2021 were not on file and available for review for Resident #1. 2. At 2:03 PM on 3/28/23 the Executive Director confirmed a significant change assessment was not on file and available for review for Resident #1 following significant decline in mental and physical status. This decline was noted as reported to Resident #1's physician and mental health counselor in February of 2023. Nursing notes during this time period document increased in urinary and bowel incontinence with crying, calling out, and "over reacting" when asked to return to his/her room to toilet; fecal smearing following episodes of fecal incontinence; attention seeking behaviors; and regressive behaviors including thumb sucking, child-like speech, and calling staff "Mama". Refusing to walk; abruptly deciding not to walk with poorly controlled sitting down on the floor; and use of a wheelchair and mechanical lift not previously required were also noted.	R144		
R190 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.12.b.(4) The results of the criminal record and adult abuse registry checks for all staff. This REQUIREMENT is not met as evidenced by:	R190	**Corrective Action to be accomplished**. Both criminal record and abuse registry checks were completed and provided to the survey team in March and the beginning of April 2023. **Measures Implemented to ensure it does not recur** MPC has a revised onboarding checklist to be completed and signed by the Business Office Director. Background checks must be completed prior to the employee starting new hire orientation. Review of Policy and Procedure for background checks completed by all Departmental Mangers. **QA Program Action to Monitor compliance with corrective measures** Our monthly QA monitoring program will now include a review of the new hire process.	4/7/23 8/10/23 6/30/23 8/10/23

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R190	Continued From page 4 Based on record review and staff interview there was a failure to complete criminal record and abuse registry checks for the Executive Director and Registered Nurse. Findings include: On the afternoon of 3/28/23 the Executive Director confirmed criminal record and abuse registry check were not completed upon hire for the Executive Director and the Registered Nurse.	R190	Tag R190 accepted on 8/1/23 - C. Scott	
R207 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.18 Reporting of Abuse, Neglect or Exploitation 5.18.b The licensee and staff are required to report suspected or reported incidents of abuse, neglect or exploitation. It is not the licensee's or staff's responsibility to determine if the alleged incident did occur or not; that is the responsibility of the licensing agency. A home may, and should, conduct its own investigation. However, that must not delay reporting of the alleged or suspected incident to Adult Protective Services. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview there was a failure to report suspected incidents of abuse and exploitation for 2 applicable residents (Residents #1 and #2) . Findings include: 1. On the afternoon of 3/28/23 the Executive Director confirmed there was a delay in reporting an incident of alleged or suspected of abuse of Resident #1 that occurred on 3/7/23 to the Adult Protective Services (APS) and the Division of Licensing and Protection (DLP). Staff reported an incident to the Executive Director during which	R207	**Corrective Action to be accomplished**. Review of MPC Policy and Procedure on Abuse and Neglect completed by Executive Director. **Measures Implemented to ensure it does not recur** MPC reports all suspected or reported incidents of abuse, neglect, or exploitation within 48 hours of the report. **QA Program Action to Monitor compliance with corrective measures** Monthly Reports of all reportable events will be shared at the monthly QAPI meetings. Tag R207 accepted on 8/1/23 - C. Scott	3/29/23 3/26/23 8/10/23

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R207	Continued From page 5 the Registered Nurse repeatedly directed a resident to walk as s/he stated s/he was in pain, unable to walk, and needed to sit down. The resident sustained a fracture during a fall while being ambulated by staff and directed to walk. The incident was reported on 3/16/23, 9 days after the incident occurred. 2. Per record review and interview with the Executive Director (ED) on 3/28/23 at 5:30 PM concerns were identified on 7/27/22 when staff notified the ED of improper storage of narcotics by the Health Services Director (HSD) and the pale appearance of liquid Morphine which is dyed blue by the manufacturer. Additionally, the HSD failed to follow the ED's instructions to dispose of the discolored Morphine on July 29, 2022. An internal investigation was performed including statements written by the staff involved and an audit of narcotic log book for Resident #2. During the course of the internal investigation the improper storage and accounting of morphine, and the failure to document the removal of morphine from the designated locked storage area, and a 3-day delay in wasting the discolored morphine were confirmed. On the afternoon of 3/28/23 the Executive Director confirmed the policy and procedures for proper storage of narcotics were not followed by the HSD, and confirmed the incident was not reported to Survey and Certification and the Adult Protective Services.	R207	**Corrective Action to be accomplished**. New Policy Created for Missing Narcotics which includes reporting all alleged reports of diversion and/or resident harm related to missing narcotics to Licensing and Protection, APS, and the Bradford Police Department. **Measures Implemented to ensure it does not recur** Executive Director) is responsible for timely reporting and Director of Health Services is responsible for following and auditing all policy and procedures for storage and accounting of narcotics. New process created: Director of Health Services and/or Resident Care Manager inspect the narcotic book and MPC narcotic storage 3 times a week and sign off on the inspection. Education on diversion will be included in MPC Medication Technician education. **QA Program Action to Monitor compliance with corrective measures** Monthly reports of the narcotics process will be included in the monthly QAPI meetings. Tag R207 accepted on 8/1/23 - C. Scott	6/1/23 4/1/23 4/7/23 8/10/23